is not reimbursed as required by paragraph (h) of this section, the third party payer must reimburse Medicare even though it has already reimbursed the beneficiary or other party.

(2) The provisions of paragraph (i)(1) of this section also apply if a third party payer makes its payment to an entity other than Medicare when it is, or should be, aware that Medicare has made a conditional primary payment.

(3) In situations that involve procurement costs, the rule of §411.37(b) applies.

(j) *Recovery against Medicaid agency.* If a third party payment is made to a State Medicaid agency and that agency does not reimburse Medicare, HCFA may reduce any Federal funds due the Medicaid agency (under title XIX of the Act) by an amount equal to the Medicare payment or the third party payment, whichever is less.

(k) *Recovery against Medicare contractor.* If a Medicare contractor, including an intermediary or carrier, also insures, underwrites, or administers as a third party administrator, a program or plan that is primary to Medicare, and does not reimburse Medicare, HCFA may offset the amount owed against any funds due the intermediary or carrier under title XVIII of the Act or due the contractor under the contract.

(l) *Recovery when there is failure to file a proper claim.* (1) *Basic rule.* If Medicare makes a conditional payment with respect to services for which the beneficiary or provider or supplier has not filed a proper claim with a third party payer, and Medicare is unable to recover from the third party payer, Medicare may recover from the beneficiary or provider or supplier that was responsible for the failure to file a proper claim.

(2) *Exceptions:* (i) This rule does not apply in the case of liability insurance nor when failure to file a proper claim is due to mental or physical incapacity of the beneficiary.

(ii) HCFA will not recover from providers or suppliers that are in compliance with the requirements of §489.20 of this chapter and can show that the reason they failed to file a proper claim is that the beneficiary, or someone acting on his or her behalf, failed to give, or gave erroneous, information regarding coverage that is primary to Medicare.

(m) *Interest charges.* (1) With respect to recovery of payments for items and services furnished before October 31, 1994, HCFA charges interest, exercising common law authority in accordance with 45 CFR 30.13, consistent with the Federal Claims Collection Act (31 U.S.C. 3711).

(2) In addition to its common law authority with respect to recovery of payments for items and services furnished on or after October 31, 1994, HCFA charges interest in accordance with section 1862(b)(2)(B)(i) of the Act. Under that provision—

(i) HCFA may charge interest if reimbursement is not made to the appropriate trust fund before the expiration of the 60-day period that begins on the date on which notice or other information is received by HCFA that payment has been or could be made under a primary plan;

(ii) Interest may accrue from the date when that notice or other information is received by HCFA and is charged until reimbursement is made; and

(iii) The rate of interest is that provided at 42 CFR 405.376(d).

[54 FR 41734, Oct. 11, 1989, as amended at 55 FR 1820, Jan. 19, 1990; 60 FR 45361, 45362, Aug. 31, 1995]

§411.25 Third party payer's notice of mistaken Medicare primary payment.

(a) If a third party payer learns that HCFA has made a Medicare primary payment for services for which the third party payer has made or should have made primary payment, it must give notice to that effect to the Medicare intermediary or carrier that paid the claim.

(b) The notice must describe the specific situation and the circumstances (including the particular type of insurance coverage as specified in §411.20(a)) and, if appropriate, the time period during which the insurer is primary to Medicare.

(c) If a plan is self–insured and self–administered, the employer must give

the notice to HCFA. Otherwise, the insurer, underwriter, or third party administrator must give the notice.

[54 FR 41734, Oct. 11, 1989; as amended at 55 FR 1820, Jan. 19, 1990]

§ 411.26 Subrogation and right to intervene.

(a) *Subrogation.* With respect to services for which Medicare paid, HCFA is subrogated to any individual, provider, supplier, physician, private insurer, State agency, attorney, or any other entity entitled to payment by a third party payer.

(b) *Right to intervene.* HCFA may join or intervene in any action related to the events that gave rise to the need for services for which Medicare paid.

§ 411.28 Waiver of recovery and compromise of claims.

(a) HCFA may waive recovery, in whole or in part, if the probability of recovery, or the amount involved, does not warrant pursuit of the claim.

(b) General rules applicable to compromise of claims are set forth in subpart F of part 401 and §405.376 of this chapter.

(c) Other rules pertinent to recovery are contained in subpart C of part 405 of this chapter.

[54 FR 41734, Oct. 11, 1989, as amended at 61 FR 63749, Dec. 2, 1996]

§ 411.30 Effect of third party payment on benefit utilization and deductibles.

(a) *Benefit utilization.* Inpatient psychiatric hospital and SNF care that is paid for by a third party payer is not counted against the number of inpatient care days available to the beneficiary under Medicare Part A.

(b) *Deductibles.* Expenses for Medicare covered services that are paid for by third party payers are credited toward the Medicare Part A and Part B deductibles.

§ 411.31 Authority to bill third party payers for full charges.

(a) The fact that Medicare payments are limited to the DRG amount, or the reasonable charge, reasonable cost, capitation or fee schedule rate, does not affect the amount that a third party payer may pay.

(b) With respect to workers' compensation plans, no-fault insurers, and employer group health plans, a provider or supplier may bill its full charges and expect those charges to be paid unless there are limits imposed by laws other than title XVIII of the Act or by agreements with the third party payer.

§ 411.32 Basis for Medicare secondary payments.

(a) *Basic rules.* (1) Medicare benefits are secondary to benefits payable by a third party payer even if State law or the third party payer states that its benefits are secondary to Medicare benefits or otherwise limits its payments to Medicare beneficiaries.

(2) Except as provided in paragraph (b) of this section, Medicare makes secondary payments, within the limits specified in paragraph (c) of this section and in §411.33, to supplement the third party payment if that payment is less than the charges for the services and, in the case of services paid on other than a reasonable charge basis, less than the gross amount payable by Medicare under §411.33(e).

(b) *Exception.* Medicare does not make a secondary payment if the provider or supplier is either obligated to accept, or voluntarily accepts, as full payment, a third party payment that is less than its charges.

(c) *General limitation: Failure to file a proper claim.* When a provider or supplier, or a beneficiary who is not physically or mentally incapacitated, receives a reduced third party payment because of failure to file a proper claim, the Medicare secondary payment may not exceed the amount that would have been payable under §411.33 if the third party payer had paid on the basis of a proper claim.

The provider, supplier, or beneficiary must inform HCFA that a reduced payment was made, and the amount that would have been paid if a proper claim had been filed.

§ 411.33 Amount of Medicare secondary payment.

(a) *Services for which HCFA pays on a Medicare fee schedule or reasonable charge basis.* The Medicare secondary payment is the lowest of the following: